		FOR OHF USE					

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0044768

Facility Name: Maryhaven Nsg & Rehabilitation

Address: 1700 East Lake Ave. (Number) Glenview (City) 60025 (Zip Code)

County: Cook

Telephone Number: (847) 729-1300 **Fax #** (847) 729-9620

IDPA ID Number: 237061646010

Date of Initial License for Current Owners: 03/01/2000

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	X	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code	501(c)(3)			Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: Christine A. Hanover **Telephone Number:** (312) 634-4581
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/2003 to 06/30/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title)
(Firm Name & Address) Altschuler, Melvoin and Glasser LLP, One South Wacker Drive, Suite 800, Chicago, IL 60606
(Telephone) (312) 384-6000 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maryhaven Nsg & Rehabilitation # 0044768 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	42	Skilled (SNF)	42	15,372	1
2		Skilled Pediatric (SNF/PED)			2
3	93	Intermediate (ICF)	93	34,038	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	135	TOTALS	135	49,410	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	6,375	5,360	2,404	14,139	8
9	SNF/PED					9
10	ICF	16,732	10,506		27,238	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,107	15,866	2,404	41,377	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.74%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 03/01/2000

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 03/01/2000 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 10 and days of care provided 2,404

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [X]

Tax Year: 12/31 Fiscal Year: 6/30

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maryhaven Nsg & Rehabilitation # 0044768 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	440,315	28,528	7,545	476,388		476,388		476,388			1
2	Food Purchase		227,013		227,013		227,013	(20,123)	206,890			2
3	Housekeeping	178,658			178,658		178,658		178,658			3
4	Laundry	101,033	58,847		159,880		159,880	(31,287)	128,593			4
5	Heat and Other Utilities			166,102	166,102		166,102		166,102			5
6	Maintenance	79,817	22,202	95,027	197,046		197,046		197,046			6
7	Other (specify):*											7
8	**TOTAL General Services**	799,823	336,590	268,674	1,405,087		1,405,087	(51,410)	1,353,677			8
	B. Health Care and Programs											
9	Medical Director			4,200	4,200		4,200		4,200			9
10	Nursing and Medical Records	2,100,010	38,499	25,077	2,163,586		2,163,586	5,570	2,169,156			10
10a	Therapy	59,949	3,640	25,527	89,116		89,116		89,116			10a
11	Activities	195,762	4,162	9,957	209,881		209,881		209,881			11
12	Social Services	69,622			69,622		69,622		69,622			12
13	Nurse Aide Training											13
14	Program Transportation			80	80		80		80			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,425,343	46,301	64,841	2,536,485		2,536,485	5,570	2,542,055			16
	C. General Administration											
17	Administrative	88,703		520,562	609,265		609,265	(520,562)	88,703			17
18	Directors Fees											18
19	Professional Services			18,789	18,789		18,789	(433)	18,356			19
20	Dues, Fees, Subscriptions & Promotions			4,814	4,814		4,814		4,814			20
21	Clerical & General Office Expenses	96,318	51,825	32,912	181,055		181,055	331,934	512,989			21
22	Employee Benefits & Payroll Taxes			1,166,860	1,166,860		1,166,860	36,696	1,203,556			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,118	3,118		3,118		3,118			24
25	Other Admin. Staff Transportation			1,119	1,119		1,119		1,119			25
26	Insurance-Prop.Liab.Malpractice			161,209	161,209		161,209		161,209			26
27	Other (specify):*											27
28	**TOTAL General Administration**	185,021	51,825	1,909,383	2,146,229		2,146,229	(152,365)	1,993,864			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,410,187	434,716	2,242,898	6,087,801		6,087,801	(198,205)	5,889,596			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000. SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Maryhaven Nsg & Rehabilitation #0044768 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			534,413	534,413		534,413	43,528	577,941			30
31	Amortization of Pre-Op. & Org.			13,944	13,944		13,944		13,944			31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			16,681	16,681		16,681		16,681			35
36	Other (specify):*											36
37	**TOTAL Ownership**			565,038	565,038		565,038	43,528	608,566			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		397,591		397,591		397,591		397,591			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			74,116	74,116		74,116		74,116			42
43	Other (specify):* Nonallowable Costs			8,908	8,908		8,908	(8,908)				43
44	**TOTAL Special Cost Centers**		397,591	83,024	480,615		480,615	(8,908)	471,707			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,410,187	832,307	2,890,960	7,133,454		7,133,454	(163,585)	6,969,869			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maryhaven Nsg & Rehabilitation # 0044768 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,162)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(31,287)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(27,302)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (60,751)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(102,834)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (102,834)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (163,585)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Maryhaven Nsg & Rehabilitation

ID# 0044768

Report Period Beginning: 07/01/2003

Ending: 06/30/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Offset tray service	$ (17,961)	2	1
2	Disallow marketing	(8,908)	43	2
3	Disallow out-of-period legal	(433)	19	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(27,302)		49

Maryhaven Nsg & Rehabilitation
Provider #: 0044768
07/01/2003 to 06/30/2004 **Schedule 5A**

VI. Adjustment Detail
Line 29 - Other

Non-allowable expenses	Amount	Reference

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Maryhaven Nsg & Rehabilitation # 0044768 **Report Period Beginning:** 07/01/2003 **Ending:** 06/30/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(20,123)	0	0	0	0	0	0	0	0	0	0	(20,123)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(31,287)	0	0	0	0	0	0	0	0	0	0	(31,287)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(51,410)	0	0	0	0	0	0	0	0	0	0	(51,410)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	5,570	0	0	0	0	0	0	0	0	0	5,570	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	5,570	0	0	0	0	0	0	0	0	0	5,570	16
	C. General Administration													
17	Administrative	0	(520,562)	0	0	0	0	0	0	0	0	0	(520,562)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(433)	0	0	0	0	0	0	0	0	0	0	(433)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	331,934	0	0	0	0	0	0	0	0	0	331,934	21
22	Employee Benefits & Payroll Taxes	0	36,696	0	0	0	0	0	0	0	0	0	36,696	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(433)	(151,932)	0	0	0	0	0	0	0	0	0	(152,365)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(51,843)	(146,362)	0	0	0	0	0	0	0	0	0	(198,205)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Maryhaven Nsg & Rehabilitation # 0044768 **Report Period Beginning:** 07/01/2003 **Ending:** 06/30/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	43,528	0	0	0	0	0	0	0	0	0	43,528	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	43,528	0	0	0	0	0	0	0	0	0	43,528	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(8,908)	0	0	0	0	0	0	0	0	0	0	(8,908)	43
44	**TOTAL Special Cost Centers**	(8,908)	0	0	0	0	0	0	0	0	0	0	(8,908)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(60,751)	(102,834)	0	0	0	0	0	0	0	0	0	(163,585)	45

Facility Name & ID Number Maryhaven Nsg & Rehabilitation # 0044768 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Resurrection Health Care	100	See attached list				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	10	Nursing Supplies	$	Resurrection Health Care	100.00%	$ 5,570	$ 5,570	1
2	V	21	Other Administrative & general		Resurrection Health Care	100.00%	171,422	171,422	2
3	V	21	Clerical & data processing		Resurrection Health Care	100.00%	160,512	160,512	3
4	V	22	Employee Benefits		Resurrection Health Care	100.00%	36,696	36,696	4
5	V	30	Depreciation		Resurrection Health Care	100.00%	43,528	43,528	5
6	V	17	Management fees	520,562	Resurrection Health Care	100.00%		(520,562)	6
7	V	39	Intercompany pharmacy	393,501	Resurrection Health Care	100.00%	393,501		7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 914,063			$ 811,229	$ * (102,834)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maryhaven Nsg & Rehabilitation # 0044768 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2	See attached page 7A										2
3											3
4											4
5											5
6											6
7											7
8	Sister Elizabeth Tremczynski	Director	Board of Directors	0.00	111,240						8
9	*Sister Elizabeth is also listed on the attached Board of Directors listing.										9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Maryhaven Nsg & Rehabilitation # 0044768 Report Period Beginning: 07/01/2003 Ending: 6/30/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Resurrection HC/Medical Center
Street Address: 7435 W. Talcott
City / State / Zip Code: Chicago, IL 60631
Phone Number: (773) 774-8000
Fax Number: (773) 594-7488

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Nursing Supplies				$	$		$ 5,570	1
2	21	Other administrative & general							171,422	2
3	21	Clerical & data processing							160,512	3
4	22	Employee Benefits							36,696	4
5	30	Depreciation							43,528	5
6	39	Intercompany pharmacy							393,501	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 811,229	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maryhaven Nsg & Rehabilitation # 0044768 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2	N/A											2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** N/A **Line #**

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

SEE ACCOUNTANTS' COMPILATION REPORT

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Maryhaven Nsg & Rehabilitation # 0044768 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$		7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1999		8
2000		9
2001		10
2002		11
2003	N/A	12

Facility is a not-for-profit entity and pays no real estate taxes.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Maryhaven Nsg & Rehabilitatior COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0044768

CONTACT PERSON REGARDING THIS REPORT Lou Fragoso

TELEPHONE (773)594-8556 FAX #: (773)594-8567

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200:

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.		N/A	$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2004

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maryhaven Nsg & Rehabilitation # 0044768 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 83,762 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground
(such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 69,720 2. Number of Years Over Which it is Being Amortized: 5

3. Current Period Amortization: 13,944 4. Dates Incurred: 2000

Nature of Costs: Organizational Costs
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		2000	$ 3,000,000	1
2					2
3	TOTALS			$ 3,000,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maryhaven Nsg & Rehabilitation # 0044768 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	134		2000	1961	$ 5,932,922	$ 197,764	30	$ 197,764	$	$ 858,471	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Facility			2000	7,995		10				9
10	Plumbing			2001	7,539		10				10
11	Architect Fees			2001	3,299		20				11
12	Architect Fees			2001	3,097		20				12
13	Landscape Architect			2001	1,478		20				13
14	Topographic mapping			2001	9,386		20				14
15	Cooler Repair			2000	766		20				15
16	Hot water softener			2001	1,150		20				16
17	Freezer repair			2001	974		20				17
18	HVAC			2001	563		20				18
19	HVAC			2001	872		20				19
20	Fire panel			2001	775		20				20
21	Mechanical repairs			2001	3,565		20				21
22	Cooler repair			2001	4,121		20				22
23	Water chiller			2000	49,020		15				23
24	Professional services, renovation			2001	20,422		10				24
25	Landscape Architect			2001	11,815		20				25
26	Floor painting			2001	499		20				26
27	Stainless steel kick plate			2001	893		20				27
28	Dry wall guard			2001	775		20				28
29	Windows			2001	994		20				29
30	Heating & cooling			2002	623		20				30
31	Swing door gaskets			2002	599		20				31
32	Remove work duct			2002	971		20				32
33	Air coil			2002	951		20				33
34	Reconnect work duct			2002	643		20				34
35	Water main repair			2001	1,880		20				35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Maryhaven Nsg & Rehabilitation # 0044768 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Electrical	2002	$ 861	$	20	$	$	$	37
38	Lock hardware	2002	673		20				38
39	Lock hardware	2002	698		20				39
40	Steel Craft metal door	2002	713		20				40
41	Tile	2002	1,078		20				41
42	Sentronics	2002	1,182		20				42
43	Asbestos abatement	2001	9,820		20				43
44	Architect services & entry, hall, library	2001	155,084		20				44
45	Landscaping Architecture	2002	11,193		20				45
46	Telephone re-wiring	2001	2,411		20				46
47	Boilers	2002	59,639		20				47
48	Boilers	2001	21,400		20				48
49	Boilers	2002	64,768		20				49
50	Construction, entry, hall, library	2002	1,279,284		20				50
51	Boiler replacement	2003	169,727		10				51
52	Landscaping Architecture	2003	26,038		10				52
53	Voice cable	2003	1,137		10				53
54	Piping	2003	91,907		10				54
55	Water retention	2003	5,071		10				55
56	Air compressor	2003	12,077		10				56
57									57
58	Phase II Site Drainage - 7/25/03	2003	2,649	88	15	88		88	58
59	Prof. Engin. Civil Services	2003	994	50	10	50		50	59
60	Repair Check Valve in Circuit #2	2003	5,014	251	10	251		251	60
61	Private Office LLB - 9	2003	1,428	48	15	48		48	61
62	Phase II Site Drain - Pr.S. 9/27/03 - 10/31/03	2003	362	12	15	12		12	62
63	Install side steam filter system	2003	2,695	135	10	135		135	63
64	Install heat-timer control system	2003	6,980	349	10	349		349	64
65	Install 4 plastic laminate gates at nurses stations	2004	1,760	59	15	59		59	65
66	Installation of 67 fire dampers	2004	20,560	1,028	10	1,028		1,028	66
67	Installation of new phone & paging system	2004	10,592	530	10	530		530	67
68	Nortel Norstar voicemail call pilot 150 new	2004	3,000	300	5	300		300	68
69	Installation of new LCN 7780 series control	2004	2,383	119	10	119		119	69
70	TOTAL (lines 4 thru 69)		$ 8,041,765	$ 200,733		$ 200,733	$	$ 861,440	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Maryhaven Nsg & Rehabilitation # 0044768 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 8,041,765	$ 200,733		$ 200,733	$	$ 861,440	1
2	Labor & material to install 2 new hot water boilers	2004	46,411	2,321	10	2,321		2,321	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32	Management allocation					43,528	43,528		32
33	Financial Statement Depreciation			234,805		234,805		534,567	33
34	TOTAL (lines 1 thru 33)		$ 8,088,176	$ 437,859		$ 481,387	$ 43,528	$ 1,398,328	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Maryhaven Nsg & Rehabilitation # 0044768 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 870,602	$ 95,452	$ 95,452	$	10	$ 568,621	71
72	Current Year Purchases	956	96	96		5	96	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 871,558	$ 95,548	$ 95,548	$		$ 568,717	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	Ford E350 Van	2001	$ 5,030	$ 1,006	$ 1,006	$	5	$ 3,856	76
77										77
78										78
79										79
80	TOTALS			$ 5,030	$ 1,006	$ 1,006	$		$ 3,856	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 11,964,764	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 534,413	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 577,941	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 43,528	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,970,901	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	N/A	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Maryhaven Nsg & Rehabilitation # 0044768 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 16,681 Description: Copiers - $13,559; Nursing Equip - $1,376; Postage Machine $1,746
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$ N/A	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maryhaven Nsg & Rehabilitation # 0044768 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
[ ] YES
[X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A (1,2,3)	233 hrs	$ 6,410	1,569	$ 17,263	$ 73	1,802	$ 23,746	1
2	Licensed Speech and Language Development Therapist	10A (2,3)	hrs		751	8,264	3,567	751	11,831	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A (1)	1947 hrs	53,539				1,947	53,539	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 (2)	# of prescrpts				393,501		393,501	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Laboratory	39 (2)					4,090		4,090	13
14	TOTAL			$ 59,949	2,320	$ 25,527	$ 401,231	4,500	$ 486,707	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Maryhaven Nsg & Rehabilitation
Provider #: 0044768
07/01/2003 to 06/30/2004 **Schedule 16A**

XIV. Special Services
Line 13 Other (specify):

Service	Line Reference	Outside Practioner Units	Cost	Supplies

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maryhaven Nsg & Rehabilitation # 0044768 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 70,589	$ 70,589	1
2	Cash-Patient Deposits	27,970	27,970	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 137,119)	61,987	61,987	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	10,718	10,718	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 171,264	$ 171,264	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	3,000,000	3,000,000	13
14	Buildings, at Historical Cost	7,629,786	5,932,922	14
15	Leasehold Improvements, at Historical Cost	49,045	2,155,254	15
16	Equipment, at Historical Cost	1,285,933	876,588	16
17	Accumulated Depreciation (book methods)	(1,970,901)	(1,970,901)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	69,720	69,720	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(60,424)	(60,424)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 10,003,159	$ 10,003,159	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 10,174,423	$ 10,174,423	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 28,380	$ 28,380	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	33,912	33,912	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to related parties	975,504	975,504	36
37	IDPA Pending contingency	80,072	80,072	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,117,868	$ 1,117,868	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,117,868	$ 1,117,868	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 9,056,555	$ 9,056,555	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 10,174,423	$ 10,174,423	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Maryhaven Nsg & Rehabilitation # 0044768 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 9,867,786	1
2	Restatements (describe):		2
3	**Prior year adjustment**	9,348	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 9,877,134	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(820,579)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (820,579)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 9,056,555	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maryhaven Nsg & Rehabilitation # 0044768 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,175,486	1
2	Discounts and Allowances for all Levels	(2,048,806)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,126,680	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	448,160	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 448,160	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	24,338	13
14	Non-Patient Meals	20,123	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	470,884	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	4,017	19
20	Radiology and X-Ray		20
21	Other Medical Services	186,434	21
22	Laundry	31,287	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 737,083	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	6	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 6	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous	946	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 946	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,312,875	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,405,087	31
32	Health Care	2,536,485	32
33	General Administration	2,146,229	33
	B. Capital Expense		
34	Ownership	565,038	34
	C. Ancillary Expense		
35	Special Cost Centers	406,499	35
36	Provider Participation Fee	74,116	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,133,454	40
41	**Income before Income Taxes (line 30 minus line 40)****	(820,579)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (820,579)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation. Tax year and fiscal year differ.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Maryhaven Nsg & Rehabilitation # 0044768 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,888	2,080	$ 71,501	$ 34.38	1
2	Assistant Director of Nursing	1,265	1,477	56,207	38.05	2
3	Registered Nurses	22,942	25,644	730,170	28.47	3
4	Licensed Practical Nurses	8,198	9,159	204,665	22.35	4
5	Nurse Aides & Orderlies	66,765	73,326	921,710	12.57	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	2,061	2,179	59,949	27.51	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,744	2,123	37,183	17.51	9
10	Activity Assistants	11,090	12,223	158,579	12.97	10
11	Social Service Workers	3,247	3,633	69,622	19.16	11
12	Dietician	588	636	14,110	22.19	12
13	Food Service Supervisor	4,012	4,829	103,825	21.50	13
14	Head Cook	7,836	8,552	110,171	12.88	14
15	Cook Helpers/Assistants	22,024	23,902	212,209	8.88	15
16	Dishwashers					16
17	Maintenance Workers	3,989	4,450	79,817	17.94	17
18	Housekeepers	18,341	19,915	178,658	8.97	18
19	Laundry	9,412	10,227	101,033	9.88	19
20	Administrator	1,832	2,099	88,703	42.26	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,172	6,758	96,318	14.25	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,958	2,137	30,711	14.37	31
32	Other Health Ca See Sch 20A	3,579	4,164	85,046	20.42	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	198,943	219,513	$ 3,410,187 *	$ 15.54	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	4,200	9 (3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 4,200		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	165	$ 9,284	10 (3)	50
51	Licensed Practical Nurses	164	5,750	10 (3)	51
52	Nurse Aides	458	10,043	10 (3)	52
53	TOTAL (lines 50 - 52)	787	$ 25,077		53

Resurrection Nursing Center
Provider #: 0044768
07/01/2003 to 06/30/2004 **Schedule 20A**

XVIII. A. Staffing & Salary Costs

Line 32 Other Health Care :

Description	Hours Worked	Hours Paid	Total Wages	Average Hourly Wage
Care Plan Coordinator	1,616	1,980	55345	27.95
Audiologist	47	47	1129	24.02
Inventory Coordinator	1,916	2137	28572	13.37
Total	3,579	4,164	85,046	20.42

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maryhaven Nsg & Rehabilitation # 0044768 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Tony Madl	Administrator	0	$ 88,703
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 88,703

B. Administrative - Other

Description	Amount
Intercompany Services	$ 520,562
(Total adjusted out in column 7)	
TOTAL (agree to Schedule V, line 17, col. 3)	$ 520,562
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Seyfarth Shaw LLP	Legal	$ 18,789
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 18,789

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 36,400
Unemployment Compensation Insurance	9,710
FICA Taxes	243,285
Employee Health Insurance	655,346
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Retirement Fund	184,686
Group Life	8,108
Group Disability	17,864
Other Benefits	3,164
Employee Medical	4,280
Tuition Reimbursement	4,017
Management Allocation	36,696
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,203,556

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Life Services Network	4,615
Misc. Subscriptions	199
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 4,814

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,118
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,118

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Maryhaven Nsg & Rehabilitation
Provider #: 0044768
07/01/2003 to 06/30/2004 **Schedule 21A**

XIX. SUPPORT SCHEDULE
C. Professional Services

Total (agree to Schedule V, line 19, column 3)	**18,789**
Disallow out-of-period legal	**(433)**
Total (agree to Schedule V, line 19, column 8)	**18,356**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maryhaven Nsg & Rehabilitation # 0044768 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2	N/A												
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maryhaven Nsg & Rehabilitation # 0044768 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **LSN $4,615**

(3) Did the nursing home make political contributions or payments to a politica action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line **N/A**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **74,116**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **20,123**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **7%**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **KPMG Peat Marwick** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Audit not yet complete**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	440,315	28,528	7,545	476,388	0	476,388	0	476,388
2. Food Purchase	0	227,013	0	227,013	0	227,013	-20,123	206,890
3. Housekeeping	178,658	0	0	178,658	0	178,658	0	178,658
4. Laundry	101,033	58,847	0	159,880	0	159,880	-31,287	128,593
5. Heat and Other Utilities	0	0	166,102	166,102	0	166,102	0	166,102
6. Maintenance	79,817	22,202	95,027	197,046	0	197,046	0	197,046
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	799,823	336,590	268,674	1,405,087	0	1,405,087	-51,410	1,353,677
9. Medical Director	0	0	4,200	4,200	0	4,200	0	4,200
10. Nursing & Medical Records	2,100,010	38,499	25,077	2,163,586	0	2,163,586	5,570	2,169,156
10a. Therapy	59,949	3,640	25,527	89,116	0	89,116	0	89,116
11. Activities	195,762	4,162	9,957	209,881	0	209,881	0	209,881
12. Social Services	69,622	0	0	69,622	0	69,622	0	69,622
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	80	80	0	80	0	80
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	2,425,343	46,301	64,841	2,536,485	0	2,536,485	5,570	2,542,055
17. Administrative	88,703	0	520,562	609,265	0	609,265	-520,562	88,703
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	18,789	18,789	0	18,789	-433	18,356
20. Fees, Subscriptions & Promotion	0	0	4,814	4,814	0	4,814	0	4,814
21. Clerical & General Office	96,318	51,825	32,912	181,055	0	181,055	331,934	512,989
22. Employee Benefits & Payroll	0	0	1,166,860	1,166,860	0	1,166,860	36,696	1,203,556
23. Inservice Training & Education	0	0	0	0	0	0	0	0
24. Travel and Seminar	0	0	3,118	3,118	0	3,118	0	3,118
25. Other Admin. Staff Trans	0	0	1,119	1,119	0	1,119	0	1,119
26. Insurance-Prop.Liab.Malpractice	0	0	161,209	161,209	0	161,209	0	161,209
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	185,021	51,825	1,909,383	2,146,229	0	2,146,229	-152,365	1,993,864
29. Total General Administrative	3,410,187	434,716	2,242,898	6,087,801	0	6,087,801	-198,205	5,889,596
30. Depreciation	0	0	534,413	534,413	0	534,413	43,528	577,941
31. Amortization of Pre-Op. & Org.	0	0	13,944	13,944	0	13,944	0	13,944
32. Interest	0	0	0	0	0	0	0	0
33. Real Estate	0	0	0	0	0	0	0	0
34. Rent - Facility & Grounds	0	0	0	0	0	0	0	0
35. Rent - Equipment & Vehicles	0	0	16,681	16,681	0	16,681	0	16,681
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	565,038	565,038	0	565,038	43,528	608,566
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	397,591	0	397,591	0	397,591	0	397,591
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	74,116	74,116	0	74,116	0	74,116
43. Other (specify):*	0	0	8,908	8,908	0	8,908	-8,908	0
44. Total Special Cost Ce	0	397,591	83,024	480,615	0	480,615	-8,908	471,707
45. Grand Total	3,410,187	832,307	2,890,960	7,133,454	0	7,133,454	-163,585	6,969,869

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	70,589	70,589
2. Cash - Patient Deposits	27,970	27,970
3. Accounts & Notes Recievable	61,987	61,987
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	0	0
7. Other Prepaid Expenses	10,718	10,718
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	0	0
10. Total current assets	171,264	171,264
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	3,000,000	3,000,000
14. Buildings, at Historical Cost	7,629,786	5,932,922
15. Leasehold Improvements, Historical Cost	49,045	2,155,254
16. Equipment, at Historical Cost	1,285,933	876,588
17. Accumulated Depreciation (book methods)	-1,970,901	-1,970,901
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	69,720	69,720
20. Accum Amort - Org/Pre-Op Costs	-60,424	-60,424
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	0
24. Total Long-Term Assets	########	10,003,159
25. Total Assets	########	10,174,423
CURRENT LIABILITIES		
26. Accounts Payable	28,380	28,380
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	33,912	33,912
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	0	0
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	975,504	975,504
37. Other Current Liabilities (specify):	80,072	80,072
38. Total Current Liabilities	1,117,868	1,117,868
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	0
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	0	0
46.Total Liabilities	1,117,868	1,117,868
47.Total Equity	9,056,555	9,056,555
48.Total Liabilities and Equity	########	10,174,423

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	7,175,486
2. Discounts and Allowances for all Levels	-2,048,806
Subtotal - Inpatient Care	5,126,680
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	448,160
7. Oxygen	0
Subtotal - Anciliary Revenue	448,160
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	24,338
14. Non-Patient Meals	20,123
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	470,884
18. Sale of Supplies to Non-Patients	0
19. Laboratory	4,017
20. Radiologyand X-Ray	0
21. Other Medical Services	186,434
22. Laundry	31,287
Subtotal - Other Operating Revenue	737,083
24. Contributions	0
25. Interest and Other Investments Income	6
Subtotal - Non-Operating Revenue	6
27. Other Revenue (specify):	0
28. Other Revenue (specify):	946
Subtotal - Other Revenue	946
30. Total Revenue	6,312,875
31. General Services	1,405,087
32. Health Care	2,536,485
33. General Administration	2,146,229
34. Ownership	565,038
35. Special Cost Centers	406,499
35. Provider Participation Fee	74,116
37. Other	0
40. Total Expenses	7,133,454
41. Income Before Income Taxes	-820,579
42. Income Taxes	0
43. Net Income or Loss for the Year	-820,579

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